

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 0 9 9 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEONARD F. ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR 4 15 84			2b. HOUR 9:19 PM				
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 10-03-48		6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.				
12. CITY OR TOWN OF DEATH Columbia		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hospital County General Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Counselor		15. KIND OF BUSINESS OR INDUSTRY Federal Govt.		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MD			16b. COUNTY Howard		16c. CITY OR TOWN Columbia		16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS 8811 Drystraw Drive 21045	
17. FATHER'S NAME FIRST MIDDLE LAST Louis Anderson			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Bush			19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 1968-1970				
20. SOCIAL SECURITY NO. 579-62-4163			21. INFORMANT Yvonne Anderson			22. ADDRESS 8811 Drystraw Drive Columbia, Maryland 21045				
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest. 4589 DUE TO, OR AS A CONSEQUENCE OF (b) Long-term failure. Voluntary heart. DUE TO, OR AS A CONSEQUENCE OF (c) chron. Pold syst hypertension. Nephros. Syn. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
24. DATE OF OPERATION			25. CONDITION FOR WHICH OPERATION WAS PERFORMED			26. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			33. LOCATION STREET CITY OR TOWN COUNTY STATE				
34. I certify that (I) (this hospital) attended the deceased from 4-15 , 19 84 , to 4-15 , 19 84 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
35. SIGNATURE L.H. Chodhury			36. DEGREE MD			37. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		38. DATE SIGNED		
39. PHYSICIAN'S NAME (TYPE OR PRINT) IONIAZ. H. CAMPBELL			40. ADDRESS HOWARD COUNTY GENERAL HOSPITAL.							
41. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			42. DATE 4/20/84		43. NAME OF CEMETERY OR CREMATORY Arlington National		44. LOCATION CITY OR TOWN COUNTY STATE Arlington VA			
45. FUNERAL DIRECTOR NAME WILLIAMS FUNERAL HOME, INC.			46. ADDRESS 4339 HUNT PLACE, N.E.			47. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 19 1984 J. Davidson-Rodell				

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Yes	1968-1970	579-62-4153	Yvonne Anderson	Columbia, Maryland	8811 Dryden Drive	Bush
			Clara			
			Anderson			
MD	Howard	Columbia	x	8811 Dryden Drive	21043	
Columbia	Howard	Howard		Howard		
Washington, DC						



ROLLINS FUNERAL HOME, INC.
4330 HUNT PLACE, N.E.
WASHINGTON, D.C. 20015
APR 1 9 1984
Arlington National
Arlington National
Arlington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 11000

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARK - ASH II			2a. DATE OF DEATH MONTH DAY YEAR APRIL 19 1984		2b. HOUR 1:30 PM
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12 24 1919	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH COLUMBIA HOWARD MD		
10. CITY OR TOWN OF DEATH COLUMBIA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NONE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ARTIST	12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MO		13b. COUNTY HOWARD	13c. CITY OR TOWN COLUMBIA	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 10063 WINDSTREAM DR 21044
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD ASH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JEANETTE ALBERT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 109-18-9644	17. INFORMANT ADDRESS SALLY SHORTIDGE 10055 WINDSTREAM DR DAUGHTER		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 5559 DUE TO, OR AS A CONSEQUENCE OF (b) REGIONAL ENTERITIS, SHORT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) BOWEL SYNDROME 38 YEARS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 19 64 to APRIL 19 19 84, that (I) (we) last saw the deceased alive on APRIL 15 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Walter E. Gooch MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED APR 20, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOCH MD		22e. ADDRESS 2309 SHOREFIELD ROAD SILVER SPRING MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 4/20/84	23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO CO. MD.	
24. FUNERAL DIRECTOR NAME JOSEPH LEE CANBY		12500 INDIAN HILL DR WEST FRIENDSHIP MD		25a. DATE REC'D. BY REGISTRAR APR 23 1984	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodell			

BP.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, then any injury, or other traumatic event, the medical examiner must file a report at once.

DHM: 16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 0 0 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARENCE			2a. DATE OF DEATH (MONTH) DAY YEAR (April) 4 13 84			2b. HOUR 11:41 A		
3. SEX male			4. RACE white			5. DATE OF BIRTH (MONTH) DAY YEAR JUNE 6 6 05		
6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			8. CITIZEN OF WHAT COUNTRY? USA		
9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.			10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Columbia Hospital General		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouseman			12b. KIND OF BUSINESS OR INDUSTRY Petroleum Co.					
13a. STATE Maryland			13b. CITY OR TOWN Montgomery			13c. CITY OR TOWN Rockville		
14. FATHER'S NAME FIRST MIDDLE LAST Edward H. Barber Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Frances Burriss					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-09-5224			17. INFORMANT ADDRESS Mary Irene Barber Same as No. 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE HOUR.
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). ALZHEIMER'S DISEASE, CVA.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3-19-1984 to 4-13-1984 , that (I) (we) lost saw the deceased alive on 4-9-1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Krishna P. Kumar						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4.13.84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KRISHNA P KUMAR.						22e. ADDRESS 11065 LITTLE PATUXENT PKY COLUMBIA MD 21044		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE APR. 16, 1984			23c. NAME OF CEMETERY OR CREMATORY Laytonsville		
23d. LOCATION CITY OR TOWN COUNTY STATE Laytonsville Mont. Md.			24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879					
DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 16 1984 Julia Davidson-Randall								

MEDICAL CERTIFICATION

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 0 0 2

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MINERVA W. BERRY			2a. DATE OF DEATH MONTH DAY YEAR April 12, 1984		2b. HOUR 6:50 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 17, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9530 Longview Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Realtor		12b. KIND OF BUSINESS OR INDUSTRY Real Estate		
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9530 Longview Drive 21043	
4. FATHER'S NAME FIRST MIDDLE LAST Joseph Winter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Dorsey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-20-0670		17. INFORMANT Donald F. Berry		ADDRESS Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure - Acute 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Breast Cancer Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Paralysis from metastatic breast cancer.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from November 1983 to April 12, 1984 , that (I) (we) lost saw the deceased alive on Feb. 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas E. Teufel				DEGREE Attending Physician		22c. DATE SIGNED 4/14/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E. Teufel				22e. ADDRESS 22 S. Greene Street, Baltimore Maryland 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/14/84		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City Md.			
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke				25a. DATE REC'D. BY REGISTRAR APR 12 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Rendell			
1630 Edmondson Avenue, Catonsville, Md. 21228									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use at the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

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Grand Canyon
Grand Canyon

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Grand Canyon

Grand Canyon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH M. BLOCK			2a. DATE OF DEATH MONTH DAY YEAR HOUR 04 13 84 4:30 A.M.	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 07 10 18	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.	
10. CITY OR TOWN OF DEATH COLUMBIA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9317 OLD LINE DRIVE, 21045		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY ---
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND	13b. COUNTY HOWARD	13c. CITY OR TOWN COLUMBIA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9317 OLD LINE DRIVE, 21045
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM MUELLER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LYDIA C. PALMER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 216-09-2968		17. INFORMANT ADDRESS LOUIS H. BLOCK 9317 OLD LINE DRIVE 21045
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest 1830 DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Adenocarcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.				
22b. SIGNATURE <i>Francis C. Grumbine</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/13/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS C. GRUMBINE, M.D.		22e. ADDRESS GBMC 6701 N. CHARLES STREET		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 04-16-84	23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.	23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229		25. DATE RECEIVED BY REGISTRAR 25a. REGISTRAR'S SIGNATURE APR 16 1984		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret G. Bond				2a. DATE OF DEATH MONTH DAY YEAR 4-28-84				2b. HOUR 4:30 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-28-93		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Columbia Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing Home				12a. USUAL OCCUPATION (IF OF HOSPITAL OR NURSING HOME, WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Howard 13c. CITY OR TOWN Ellicott City				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3114 Old Fence Rd. #21043			
14. FATHER'S NAME FIRST MIDDLE LAST William Clark				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine McPhillips					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 364-09-0078		17. INFORMANT ADDRESS B. Harry R. Bond City, Md. #21043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alzheimers Disease</u> 3310 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>adenocarcinoma of the breast.</u>									
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> N/A <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/22 19 84 to 4/28 19 84, that (I) (we) lost saw the deceased alive on 3/22 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William Flowers MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/28/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm Flowers MD				22e. ADDRESS 10802 Hickory Ridge Rd Columbia Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 2, 1984		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Howard Md.			
24. FUNERAL DIRECTOR NAME G. Thomas Schwab				25. DATE REC'D. BY REGISTRAR MAY 3 1984		25b. REGISTRAR'S SIGNATURE John T. ...			



10-28-13

Received

Office

TO THE

Department of the Interior

General Land Office

10-28-13

10-28-13

10-28-13

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 0 0 5

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Brundige BETTY L. BRUNDIGE			2a. DATE OF DEATH MONTH DAY YEAR 4 1 84		2b. HOUR 6 35 A
3. SEX Fe Female	4. RACE W White	5. DATE OF BIRTH MONTH DAY YEAR 08 24 26	6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.		
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County Gen		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Prince Geo.	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	14. STREET ADDRESS 7520 Brooklyn Bridge RD 20707	
15. FATHER'S NAME FIRST MIDDLE LAST Frank Denzler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 355 18 1963	17. INFORMANT ADDRESS Maurice M Brundige 7520 Brooklyn Bridge RD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) CARCINOMATOUS ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CARCINOMA OF THE MAXILLARY SINUS					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/1 , 19 84 , to 4/1 , 19 84 , that (I) (we) lost saw the deceased alive on 4/1 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward Wolf	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/1/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward Wolf	22e. ADDRESS 906 Belmarck, Johns Hopkins Hosp.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE April 4'84	23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans	23d. LOCATION CITY OR TOWN COUNTY STATE Garrison Forest Balto Maryland	23e. DATE REC'D. BY REGISTRAR APR 3 1984	
24. FUNERAL DIRECTOR NAME Harry H Witzke 4112 Columbia RD Ellicott City		25. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed - after 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or coroner will be notified at once.

Harry H. Wicks 4112 Columbia RD HINSCOTT CITY

Born April 4, 1908 Maryland Veterans

Garrison Forest Balco Maryland

No

255 16 1967

Harrison H. Wicks 7520 Brooklyn Bridge RD

Frank Denzler

German

Married Prince Geo. Laval

7520 Brooklyn Bridge RD 20707

Honolulu

Indiana

U.S.A.

X

Texas

White

BETTY L. BRUNDIGE

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

84

11006

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Dolores Anne Burleson			2a. DATE OF DEATH MONTH DAY YEAR April 14, 1984		2b. HOUR MIN. 5:29 A						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 7, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 51		IF UNDER 1 YEAR MONTHS DAYS YRS		IF UNDER 24 HRS HOURS MIN. M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD					
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3370 N. Chatham Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3370 N Chatham Rd 21043			
14. FATHER'S NAME FIRST MIDDLE LAST Alfred Jos. Goldwine				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Lillian Alice James							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 212 30 6882		17. INFORMANT ADDRESS Miss Linda Burleson 3370 N Chatham Rd Apt D					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 1490 DUE TO, OR AS A CONSEQUENCE OF (b) Carotid artery of pharynx DUE TO, OR AS A CONSEQUENCE OF (c) Paraneoplastic syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Paraneoplastic syndrome											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1983 to Feb 19 84 , that (I) (we) last saw the deceased alive on Feb 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard M. Hirata						DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Apr 14 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD M. HIRATA						22e. ADDRESS Ste 308 1000 Commerce Bldg Towson Md 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE April 16'84		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto.. Md.			
24. FUNERAL DIRECTOR NAME Harry H Witzke						4112 Columbia Rd Ellicott City		25a. DATE REC'D. BY REGISTRAR APR 19 1984		25b. REGISTRAR'S SIGNATURE Linda Burleson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

BP



2:29 A

April 14, 1934

Robert Anne Harrison

31

February 7, 1933

White

Female

Howard County

U.S.A.

Marriage

3370 N. Chatham Road

Ellisport City

3370 N. Chatham Rd 11043

Ellisport City

Howard

Marriage

Jane William Alice James

Alfred Joe. Collins

113 30 6882 Miss Linda Harrison 3370 N Chatham Rd Apt B

No

Gaithersville, Md.

April 16, 1934 Westview Hotel, Park

Registration

113 Columbia Rd Ellisport City

Harry H. Wilson

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

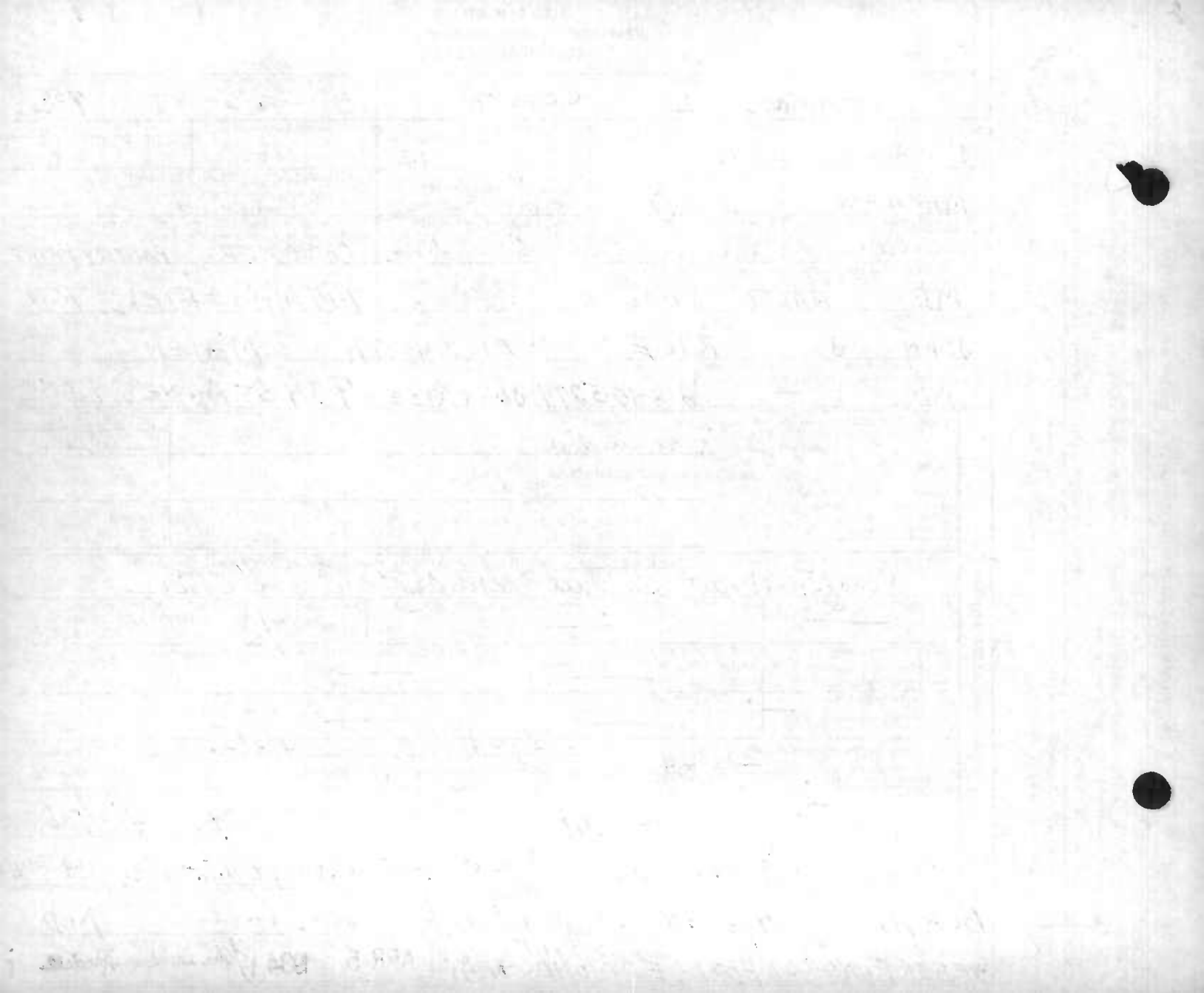
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Marian L Coburn					4 - 23 - 84					750 AM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female	W		7 - 11 - 13		70 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND	USA				Howard MD.					
10. CITY OR TOWN OF DEATH		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Columbia		Howard County General Hosp				CHECKER		PANTRY PRIME		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
MD		BALTO		BALTO		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9411 MASEFIELD RD		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		
JOHN J. RICE		ELIZABETH MAIER		NO		218-10-5297		JOHN RICE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Congestive heart failure, urinary tract infection										
9a. DATE OF OPERATION		10a. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 3/21/84, 19, to 4/3/84, 19, that (I) (we) lost saw the deceased alive on 4/2/84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Brad J. Cooper MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/3/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRAD J. COOPER, MD		22e. ADDRESS 3459 St. Johns Ln., Ellicott City, Md. 21043								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/6/84		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD		23e. DATE REC'D. BY REGISTRAR APR 5 1984		
24. FUNERAL DIRECTOR NAME WEBER FUNERAL HOME		ADDRESS 5311 EDMONDSON AVE		25a. REGISTRAR'S SIGNATURE John Davidson-Randette						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be distributed for use at the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician must be notified at the time of death.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 7B, show any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Francis Earle Crane				2a. DATE OF DEATH MONTH DAY YEAR April 29, 1984		2b. HOUR P. 3:10 P.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 23, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.			
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Milk Salesman		12b. KIND OF BUSINESS OR INDUSTRY Milk		
13a. STATE Md.				13b. COUNTY Howard	13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1150 Underwood Rd
14. FATHER'S NAME FIRST MIDDLE LAST Joseph C. Crane		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-91-0755		17. INFORMANT ADDRESS Earle E. Crane, Sykesville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4960 Chronic obstructive Pulmonary Disease IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1971			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1971 1984			
22a. I certify that (I) (this hospital) attended the deceased from April 19 1983 , to 4/29/84 , that (I) (we) lost saw the deceased alive on April 19 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Dr. E. E. Crane		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W E McGroth M.D.		22e. ADDRESS 1303 Frederick Rd Pattersonville 21228 Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-1-84		23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		23d. LOCATION (CITY OR TOWN) COUNTY STATE Ellicott City Howard Md	
24. FUNERAL DIRECTOR NAME Harry W. Haight Sykesville, Md.				25a. DATE REC'D. BY REGISTRAR MAY 2 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

②

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Armida J Culpepper			April 28 1984			2:10 P.M.			
3. SEX F		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 4 07 08		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 76		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Columbia, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Korien Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10619 South Dunmore Drive	
14. FATHER'S NAME FIRST MIDDLE LAST W. F. Hodges			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Kimbrough			16. ADDRESS 807 Downs Drive			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Ronald Culpepper-son-Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes mellitus. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21b. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] N/A			21d. LOCATION CITY OR TOWN COUNTY STATE STREET						
22a. I certify that (I) (this hospital) attended the deceased from 3/12 1984 to 4/28 84, that (I) (we) last saw the deceased alive on 3/12 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William Flowers MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/28/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Flowers MD			22e. ADDRESS 10802 Hedden Ridge Rd Columbia Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-1-1984		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home			11800 N.H. Ave., Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR MAY 2 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMMH-17
(VR A15 ME (5))
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JOHN M. DEBOY							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 4 DAY 21 YEAR 1984		2b. HOUR 1150A		
3. SEX M	4. RACE CAUS	5. DATE OF BIRTH MONTH 11 DAY 17 YEAR 2063	6. AGE (IN YEARS) LAST BIRTHDAY 63 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD 421 1984		2d. HOUR 1150A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co. MD.					
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pharmacist		12b. KIND OF BUSINESS OR INDUSTRY Drug Fair Stores			
13a. STATE MD			13b. COUNTY HOWARD		13c. CITY OR TOWN ELLCOTT CITY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9117 SYBERT DR. 21043		
14. FATHER'S NAME FIRST late Peter DeBoy MIDDLE LAST 					15. MOTHER'S MAIDEN NAME FIRST late Elizabeth MIDDLE LAST 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW 11 213 12 4704		17. INFORMANT ADDRESS Mrs Margaret DE Boy 9117 Sybert Dr 21043						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas F. Herbert				TITLE (SPECIFY) Deputy				DATE SIGNED 4-21-84			
EXAMINER'S NAME (TYPE OR PRINT) Thomas F. Herbert MD				ADDRESS Ellicott City, Md 21043							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 25 '84		23c. NAME OF CEMETERY OR CREMATORY Crest Lawn				23d. LOCATION CITY OR TOWN Marriottsville COUNTY Howard STATE Md.			
24. FUNERAL DIRECTOR NAME Harry H Witzke ADDRESS 4112 Columbia Rd Ellicott City				25a. DATE REC'D. BY REGISTRAR APR 24 1984				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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John Elsworth

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR LOUISE DEMANT					REG. NO.				
1. DECEASED NAME [TYPE OR PRINT] Louise Demant					2a. DATE OF DEATH MONTH DAY YEAR 4/4/84				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-12-89		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7b. HOUR 12¹⁰ PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6231 Sunny Spring 21044	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Dillenseger					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise (unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 065-10-7317		17. INFORMANT Mary Wells		ADDRESS Same as # 13			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory arrest 4960 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) COPD									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr days YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Alzheimers; General Ischem									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) [this hospital] attended the deceased from 3/20 to 4/3 19 84 , that (1) [we] lost saw the deceased alive on 4/3 19 84 , and that in (my) [our] opinion death occurred on the date and hour and from the causes stated above, (1) [we] did [did not] view the body after death.									
22b. SIGNATURE Melvin Gordon				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/4/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melvin Gordon				22e. ADDRESS 2000 Century Plaza Columbia Maryland 21044					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/7/84		23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery Long Island		23d. LOCATION CITY OR TOWN COUNTY STATE New York			
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke				25a. DATE REC'D. BY REGISTRAR APR 9 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			
5555 Twin Knolls Road, Columbia, Md. 21045									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DAVAL COMPTON I DUAL			2a. DATE OF DEATH MONTH DAY YEAR APRIL 28, 1984		2b. HOUR 5 A.M.
3. SEX M Male	4. RACE W White	5. DATE OF BIRTH MONTH DAY YEAR 12 07 11		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD.	
10. CITY OR TOWN OF DEATH COLUMBIA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY HOME PRODUCTS
13a. STATE MARYLAND	13b. COUNTY HOWARD	13c. CITY OR TOWN ELICOTT CITY	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 8540 MARYBETH WAY 21043	
14. FATHER'S NAME FIRST late Comoton I MIDDLE Dual LAST		15. MOTHER'S MAIDEN NAME FIRST late Mary MIDDLE McCann LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II 212 05 2155		17. INFORMANT ADDRESS Mrs Eugenia Duval 8540 Marybeth Way 21043	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1890 Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Generalized carcinomatosis 2016 DUE TO, OR AS A CONSEQUENCE OF (c) undifferentiated CA of R & L Kidney				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from APR 23, 19 84 to APR 28, 19 84 , that (I) (we) last saw the deceased alive on APR 28, 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Anthony Jean-Jacques M.D.		DEGREE		22c. DATE SIGNED 4-28-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anthony Jean-Jacques M.D.		22e. ADDRESS ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 1, 1984	23c. NAME OF CEMETERY OR CREMATORY Meadowridge	23d. LOCATION CITY OR TOWN COUNTY STATE Howard, Maryland
24. FUNERAL DIRECTOR NAME Harry H Witzke 4112 Columbia Rd Ellicott City		25a. DATE REC'D. BY REGISTRAR MAY 1 - 1984	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

THE SECRET
OF THE
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE



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Yes NW 11 312 02 2122 New Richmond Naval 12340 Harry Beth May 2102

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Barryland, Harry

May 1, 1964

Barryland

Harry H. McGinnis 4112 Columbia Rd Hillcrest City

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Minnie L. Hall			2a. DATE OF DEATH MONTH DAY YEAR 04-11-84		2b. HOUR 8²⁵ AM
3 SEX Female	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 04-07-01		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.		
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE md			13b. CITY OR TOWN Montg	13c. STREET ADDRESS 6325 Damascus Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Riggs			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Dorsey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-74-2734	17 INFORMANT ADDRESS Thelma Walden (granddaughter) 19910 Apple Ridge Rd, Gaithersburg, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) HCU D, DIABETES MELLITUS, Chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) CVA & Gangrene of L Foot					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/16/84 , 19 84 , to 4/11/84 , 19 84 , that (I) (we) lost saw the deceased alive on 4/10/84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]		22e. ADDRESS 10840 LITTLE PATUXENT PKY, COL, 7N & 2004			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 4-17-84	23c. NAME OF CEMETERY OR CREMATORY Brooke Grove Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE LAYTONSVILLE, MONTG MD.
24. FUNERAL DIRECTOR NAME George R. Snowden		DATE REC'D BY REGISTRAR APR 17 1984	



OFFICE OF THE
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LAND OFFICE

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APR 17 1904

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NATHANIEL HARRINGTON SR.			2a. DATE OF DEATH MONTH 4 DAY 9 YEAR 84		2b. HOUR 12:30 P.M.
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH 9 DAY 28 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10105 Rodona Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tractor		12b. KIND OF BUSINESS OR INDUSTRY Railroad
13a. STATE md.	13b. COUNTY Howard	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 10105 Rodona Drive 21044	
14. FATHER'S NAME FIRST LEWIS MIDDLE LAST HARRINGTON		15. MOTHER'S MAIDEN NAME FIRST Frances MIDDLE LAST Adams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 70509-6460		17. INFORMANT Mrs. Alice Harrington ADDRESS 10105 Rodona Drive	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a).

4292

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **ATHEROSCLEROTIC CARDIO-VASCULAR Dx.**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**YEARS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

ANEMIA DUE TO CHRONIC GI BLOOD LOSS.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JAN 1 , 19 83 , to APR. 9 , 19 84 , that (I) (we) last saw the deceased alive on SEPT. 11 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Barry R. Nathanson		DEGREE MD		22c. DATE SIGNED 4/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON		22e. ADDRESS 51 FRANKLIN ST. ANNAP. MD.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4-13-83	23c. NAME OF CEMETERY OR CREMATORY Pine Lawn Mem. PK.	23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS MD.
24. FUNERAL DIRECTOR NAME Randolph J. Collick ADDRESS 24316 Oliver St.		25a. DATE REC'D. BY REGISTRAR APR 16 1984	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.



THE UNIVERSITY OF CHICAGO
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Hazel Margaret Heider			2a. DATE OF DEATH MONTH DAY YEAR April 8, 1984			2b. HOUR 7:00 AM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Elkridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6934 Montgomery Rd. 21227				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Elkridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6934 Montgomery Rd. 21227	
14. FATHER'S NAME FIRST MIDDLE LAST William Ryan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gerney Willet					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Mrs. Judy I. Fittro Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of transverse colon with metastases</u> <u>1531</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Congestive heart failure.</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Alberto Del Corro</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/9/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alberto Del Corro, M.D.				22e. ADDRESS Franklin Sq. Med. Arts Bldg. 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/11/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Brooklyn A.A., Maryland			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home				ADDRESS Catonsville, Md.		25a. DATE REC'D BY REGISTRAR 4-10-84			
						25b. REGISTRAR'S SIGNATURE <u>J. A. Davis</u>			

BP _____



100% COTTON
CHEFMAN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with you after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Eva R. Hopkins			2a. DATE OF DEATH MONTH DAY YEAR April 18, 1984		2b. HOUR 10 ³⁰ PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 06 96		6. AGE ¹ (IN YEARS LAST BIRTHDAY) 87 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing Home		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. CITY OR TOWN Frederick Thurmont		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Banghart			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luretta Gunderman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 159-09-5113		17. INFORMANT Mr. Mark R. Hopkins, 6531 Mountain- dale Rd., Thurmont, Md. 21788	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5m</u> <u>6m</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>2</u> 19 <u>84</u> to <u>4</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes noted above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Dr. Warren Ross M.D.</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/19/84</u>
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Warren Ross M.D.		22e. ADDRESS Columbia, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 21, 1984		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick Md.
24. FUNERAL DIRECTOR Smith Reaney Basford P.A., Funeral Home 106 E. Church Street, Frederick, Md.				25a. DATE REC'D. BY REGISTRAR APR 23 1984		25b. REGISTRAR'S SIGNATURE <u>John E. ...</u>

BP _____

Name of Person		Address		Occupation	
John A. Smith		123 Main St.		Farmer	
Mary B. Jones		456 Oak St.		Housewife	
Robert C. Brown		789 Elm St.		Teacher	
Elizabeth D. White		101 Pine St.		Retailer	
James E. Black		202 Cedar St.		Mechanic	
Sarah F. Green		303 Birch St.		Dressmaker	
William G. Hall		404 Spruce St.		Physician	
Anna H. Young		505 Willow St.		Librarian	
Charles I. King		606 Ash St.		Engineer	
Margaret J. Lee		707 Hickory St.		Musician	
Frank K. Scott		808 Sycamore St.		Lawyer	
Helen L. Adams		909 Magnolia St.		Artist	
George M. Baker		1010 Poplar St.		Merchant	
Lucy N. Carter		1111 Chestnut St.		School Teacher	
Edward O. Evans		1212 Walnut St.		Clerk	
Florence P. Foster		1313 Elm St.		Nurse	
Harold Q. Gibson		1414 Oak St.		Student	
Irene R. Harris		1515 Pine St.		Homemaker	
John S. Jones		1616 Cedar St.		Farmer	
Katherine T. King		1717 Birch St.		Teacher	
Lester U. Lee		1818 Spruce St.		Engineer	
Mildred V. Martin		1919 Willow St.		Musician	
Norman W. Miller		2020 Ash St.		Lawyer	
Olivia X. Moore		2121 Hickory St.		Artist	
Percy Y. Myers		2222 Sycamore St.		Merchant	
Rebecca Z. Nelson		2323 Magnolia St.		School Teacher	
Samuel A. Oliver		2424 Walnut St.		Clerk	
Theresa B. Parker		2525 Elm St.		Nurse	
Victor C. Quinn		2626 Oak St.		Student	
Wendell D. Reed		2727 Pine St.		Homemaker	
Xavier E. Ryan		2828 Cedar St.		Farmer	
Yvonne F. Scott		2929 Birch St.		Teacher	
Zachary G. Smith		3030 Spruce St.		Engineer	



UNITED STATES GOVERNMENT
DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
APR 23 1934
PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (Type name) FIRST MIDDLE LAST ELIZABETH N. KNIGHT				2a. DATE OF DEATH MONTH DAY YEAR 4-25-84			
3. SEX Female		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 12 4 02		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7b. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7c. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD.	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KLORIEN NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN HALETHORPE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WINFIELD NICHOLSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA ROSS		16. SOCIAL SECURITY NO. 213-34-0685			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-34-0685		17. INFORMANT ADDRESS JANET HARTMAN 1821 ARBUTUS AVENUE, 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Aspiration APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 20's							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) SPCVA / Coma due							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12 , 19 83 , to 4 , 19 84 , that (I/we) last saw the deceased alive on 3 , 19 84 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.							
22b. SIGNATURE Warren Ross		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/25/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Warren Ross		22e. ADDRESS 11065 Little Patuxent Pkwy.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 04-28-84		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BROOKLYN PK. A.A. MARYLAND	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR APR 27 1984		25b. REGISTRAR'S SIGNATURE Pat Davidson-Randall	

BP



[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a series of lines of text, possibly a list or a report, spanning the width of the page.]

[Faint text lines, likely bleed-through from the reverse side of the page.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 0 1 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jean Kanney			2a. DATE OF DEATH MONTH DAY YEAR 04 2 84		2b. HOUR 4:55 PM
3. SEX Female	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 3 30 1920	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	9. CITIZEN OF WHAT COUNTRY? USA	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard COUNTY MD.		
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OFFICE COORDINATOR	12b. KIND OF BUSINESS OR INDUSTRY DART & KRAFT CO.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland	13b. COUNTY Howard	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS #21045 7178 Harp String	
14. FATHER'S NAME FIRST MIDDLE LAST JULIUS SCHWARTZ	15. MOTHER'S MAIDEN NAME MIDDLE MARIE KIND		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. 051147608		17. INFORMANT ADDRESS LOUIS KANNEY (21045) 7178 HARP STRING COLUMBIA, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Breast, recurrent</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchial Asthma</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/27</u> , 19 <u>84</u> to <u>3/2</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>3/2</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Richard W. Smith M.D.</u>		DEGREE M.D.	22c. DATE SIGNED 4/2/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard W. Smith		22e. ADDRESS 5999 Harpers Farm Rd Columbia MD 21045			
23a. BURIAL, CREMATION, REMOVAL BURIAL / REMOVAL	23b. DATE 4/4/84	23c. NAME OF CEMETERY OR CREMATORY BETH ISRAEL MEM. PARK	23d. LOCATION WOODBRIIDGE, N.J. COUNTY STATE		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS, 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)		25a. DATE REC'D. BY REGISTRAR APR 6 1984			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 4 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



RECEIVED
JUN 10 1917

MAILED
JUN 10 1917



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1- FOR STATE REGISTRAR			7 4 1 1 0 1 9		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ronald G. Kauffman			2a. DATE OF DEATH MONTH DAY YEAR 4-27-84		2b. HOUR 5:57 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APRIL 14 32	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 52		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard Co., MD.		
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Spec.		12b. KIND OF BUSINESS OR INDUSTRY NSA
13a. STATE Maryland		13b. COUNTY Howard	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Kauffman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE Frieda Bath		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1955-1957	17. INFORMANT ADDRESS Evelyn D. Kauffman same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (b) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Squamous Cell Carcinoma of the Lung					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/24 19 84 , to same 19 84 , that (I) (we) lost saw the deceased alive on 4/24 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Steve Hargarten		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED 4/27/84	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Steve Hargarten		22d. ADDRESS 1704 Thomas St.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/30/84	23c. NAME OF CEMETERY OR CREMATORY Balto. Wash. Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, P.G.Co. Md.
24. FUNERAL DIRECTOR FLECK FUNERAL HOME, INC.			25a. DATE REC'D. BY REGISTRAR MAY 1 - 1984		25b. REGISTRAR'S SIGNATURE C. Davidson-Randall
26. ADDRESS 7601 Sandy Spring Rd. Laurel, Md. 20701					

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

BP

DHMH - 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 0 2 0

FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Eleanore Elaine Macfarlane		2a. DATE OF DEATH MONTH DAY YEAR April 23, 1984	
3. SEX Female		7b. HOUR 4:15 PM	
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 7, 1930	
6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.	
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8614 N Ball Court	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City	
14. FATHER'S NAME FIRST MIDDLE LAST J. Raymond Hucke		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Helen Mahle	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219 28 3306	
17. INFORMANT ADDRESS John C. Macfarlane 8614 N. Ball Court 21043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angiosarcoma, metastatic 1719 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) XXXXXX attended the deceased from <u>September 9, 1968</u> , to <u>April 23, 1984</u> , that (I) XX lost saw the deceased alive on <u>20 April</u> , 19 <u>84</u> , and that in (my) XX opinion death occurred on the date and hour and from the causes stated above, (I) XX (did) XXXXXX view the body after death.			
22b. SIGNATURE <i>Wilmer K. Gallagher, Jr., M.D.</i> DEGREE		22c. DATE SIGNED 24 April 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wilmer K. Gallagher, Jr., M.D.		22e. ADDRESS 3455 Wilkens Avenue -Baltimore, MD 21229	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 26'84	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Harry H Witzke 4112 Columbia Rd Ellicott City		25a. DATE REC'D. BY REGISTRAR APR 25 1984	
25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

MEDICAL CERTIFICATION



4:15 PM	April 27, 1934	Baltimore Marine Hotel	Female	White	Feb 7, 1930	24	Howard County
			Maryland	U.S.A.			
		Allicott City	8614 N. Ball Court	Housewife			
		Maryland	Howard	Allicott City	x	8614 N. Ball Court	21043
		J. Raymond Hinton	late Helen Maria				
		219 28 1906	John G. MacFarlane	8614 N. Ball Court	21043		

Harry H. Wicks and Columbia in Allicott City
APR 27 1934
Baltimore Maryland

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Frank D Maroni			2a. DATE OF DEATH MONTH DAY YEAR 4-18-84		2b. HOUR 4¹⁰ PM
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Feb. 5, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.	
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rosen Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Mason-		12b. KIND OF BUSINESS OR INDUSTRY Construction
13a. STATE md		13b. CITY OR TOWN Montgomery	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11511 Regnid Drive 20902	
14. FATHER'S NAME FIRST MIDDLE LAST Paul Maroni		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angeline Perotti			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 188-01-9536		17. INFORMANT ADDRESS Ann Philbin Same as # 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **4960 ACUTE RESPIRATORY FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **END STAGE LUNG DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c) **CHRONIC OBSTRUCTIVE LUNG DISEASE**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
11 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

RECURRENT PNEUMONIAS.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING: <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 1983 , to 4-18-1984 , that (I) (we) lost saw the deceased alive on 4-18-1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Krishna P. Kumar		DEGREE		22c. DATE SIGNED 4-19-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KRISHNA P. KUMAR		22e. ADDRESS Suite 103 Columbia, Md 21044 11065 Little Patuxent Parkway			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/21/84	23c. NAME OF CEMETERY OR CREMATORY Italian American	23d. LOCATION CITY OR TOWN COUNTY STATE Scranton Pennsylvania
24. LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 5555 Twin Knolls Road, Columbia, Md. 21045			25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 23 1984 <i>J. Davidson</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, a temporary injury, or other traumatic event, the medical examiner may be notified at 410-327-1234.

BP _____



Pennsylvania

Belmont - Union - Commission

1950 Remid Drive 20802

Montgomery Silver Spring

Perotti

Ingelins

Kennel

Swil

Same as 1 15

and 1948

1948-1950

No

Columbia, 2014

Suite 103

1957 Little Rockway

Thailand American

1957

Swil

1957 Twin Hills Road, Columbia, Mo. 2014
1957 & 1958
1957 & 1958
1957 & 1958

Commission

Commission

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Stanley Fairall Melchior					2a. DATE OF DEATH MONTH DAY YEAR April 5, 1984			2b. HOUR 12:45 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 15, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Marriottsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1670 Henryton Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired State Highway Admin.			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Marriottsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1670 Henryton Road 21104	
14. FATHER'S NAME FIRST MIDDLE LAST late George E Melchior					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Willie Fairall				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 22 4688		17. INFORMANT ADDRESS Mrs Lois Melchior 1670 Henryton Rd 21104					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure, coronary thrombosis, 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ASHD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 1968 , 19____, to 4-5-84 , 19____, that (I) (we) last saw the deceased alive on 4-5-84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Howard E. Hall M.D. DEGREE					22c. DATE SIGNED 4-6-84			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard E. Hall, M.D., P.A.	
22e. ADDRESS PO Box 318 Sykesville, Md. 21784									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 7'84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Harry H Witzke 4112 Columbia Rd Ellicott City					25. DATE REC'D. BY REGISTRAR APR 10 1984		25b. REGISTRAR'S SIGNATURE Davidson-Randall		

MEDICAL CERTIFICATION



12:45AM

April 3, 1984

Stanley Patrick Melchior

75

Nov 13, 1908

White

Male

Howard County

#

U.S.A.

Baltimore Md.

Retired State Highway Admin.

1070 Henryton Road

Martinsville

1070 Henryton Road

Martinsville

Howard

Maryland

Late Willie Patrick

Late George E Melchior

212 22 4688 Mrs Lola Melchior 1070 Henryton Rd 21102

No



Baltimore Maryland

London Park

April 7, 84

Burial

Harry H Wickes 4112 Columbia Ellwood City

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 0 2 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Coy Lee Moody			2a. DATE OF DEATH MONTH DAY YEAR 4 2 84			2b. HOUR 4:30A M			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 22 08		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD			
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital				12a. USUAL OCCUPATION (GIVE WORK FOR MOST PRECEDING LIFE) Retired Cast Iron worker, Supt.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Moody			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte McKinnon			13e. STREET ADDRESS 3009 Fallston Ave, 20904			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW11 419-03-7018		17. INFORMANT ADDRESS Nelda A. Moody-wife- (same as 13e)				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

16229

IMMEDIATE CAUSE (a) **Respiratory Arrest**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 mi

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **Pneumonia**

1 Mo

DUE TO, OR AS A CONSEQUENCE OF

(c) **Carcinoma of Lung**

1 Mo

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

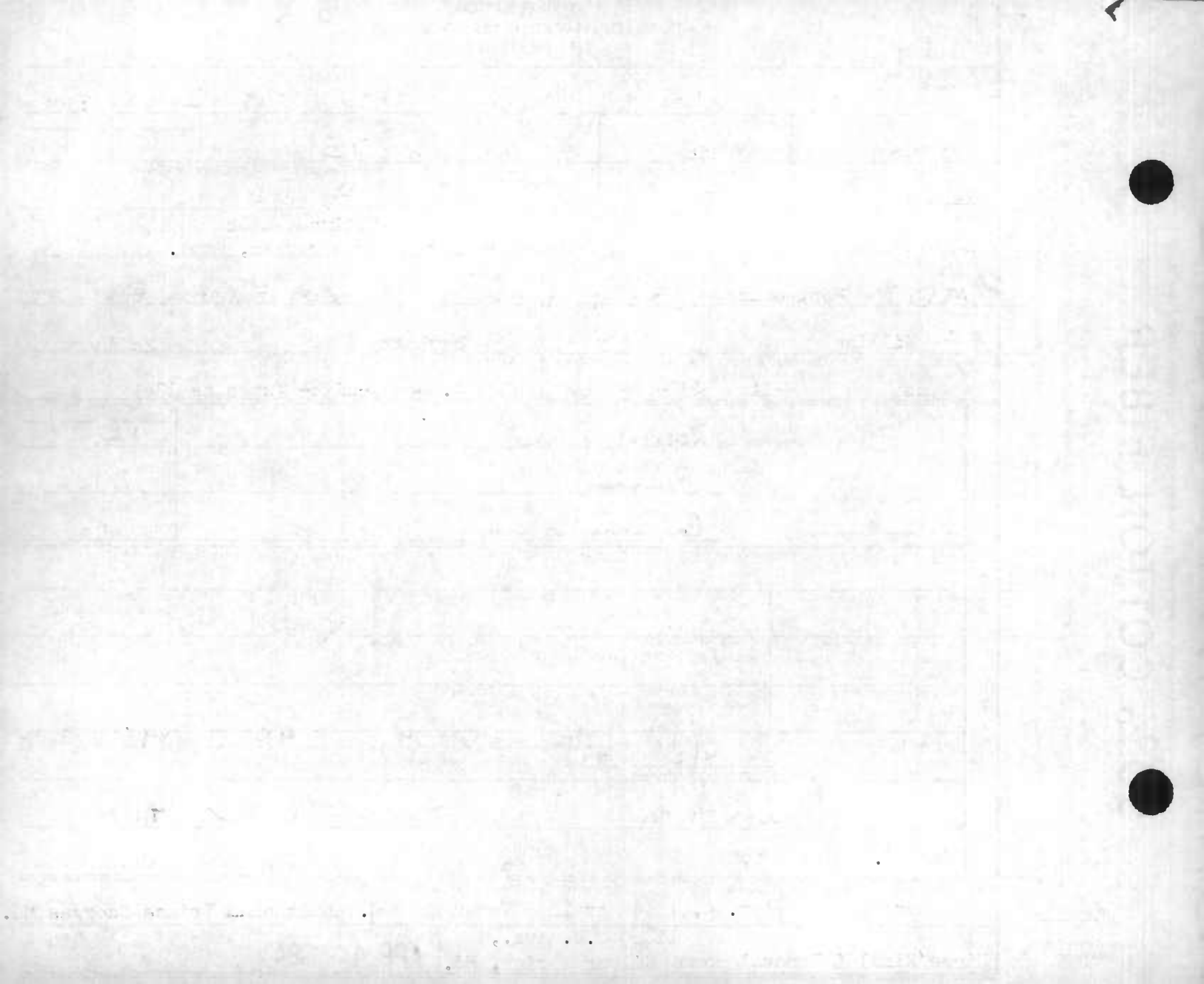
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/12 , 19 84 , to 4/2 , 19 84 , that (I) (we) last saw the deceased alive on 4/2 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Mark G. Midei		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark G. Midei, MD		22e. ADDRESS 601 N. Wolfe, Baltimore MD 21205					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 4, 1984		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem. Cheltenham Prince Georges Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		ADDRESS 11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR APR 4 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to examine the body.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 0 2 4

1- FOR
STATE
REGISTRAR

NANCY G. OWENS

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NANCY G. OWENS			2a. DATE OF DEATH MONTH DAY YEAR 4 - 26 - 84			2b. HOUR 9:50 P M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 10, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.				
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beautician		12b. KIND OF BUSINESS OR INDUSTRY Cosmotology		
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4225 Bright Bay Way 21043		
14. FATHER'S NAME FIRST MIDDLE LAST Howard Guin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Summey			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO 243-58-9072	
17. INFORMANT William M. Owens Jr.						ADDRESS Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC ADENOCARCINOMA OF COLON</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>82</u> , to <u>Apr 126</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>April 26</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Dr. L. Levine</u> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/26/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LEON I. LEVINE, M.D.</u>						22e. ADDRESS <u>10802 Hickory Ridge Rd Columbia, Md 21044</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/30/84		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Holly Gaston N Carolina			
24. FUNERAL DIRECTOR NAME LEROY M. & Russell C. Witzke						ADDRESS Funeral Home P.A. 5555 Twin Knolls Road, Columbia, Md. 21045		25a. DATE REC'D. BY REGISTRAR APR 27 1984		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon 3, 4, and 5. Carbon 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

W. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

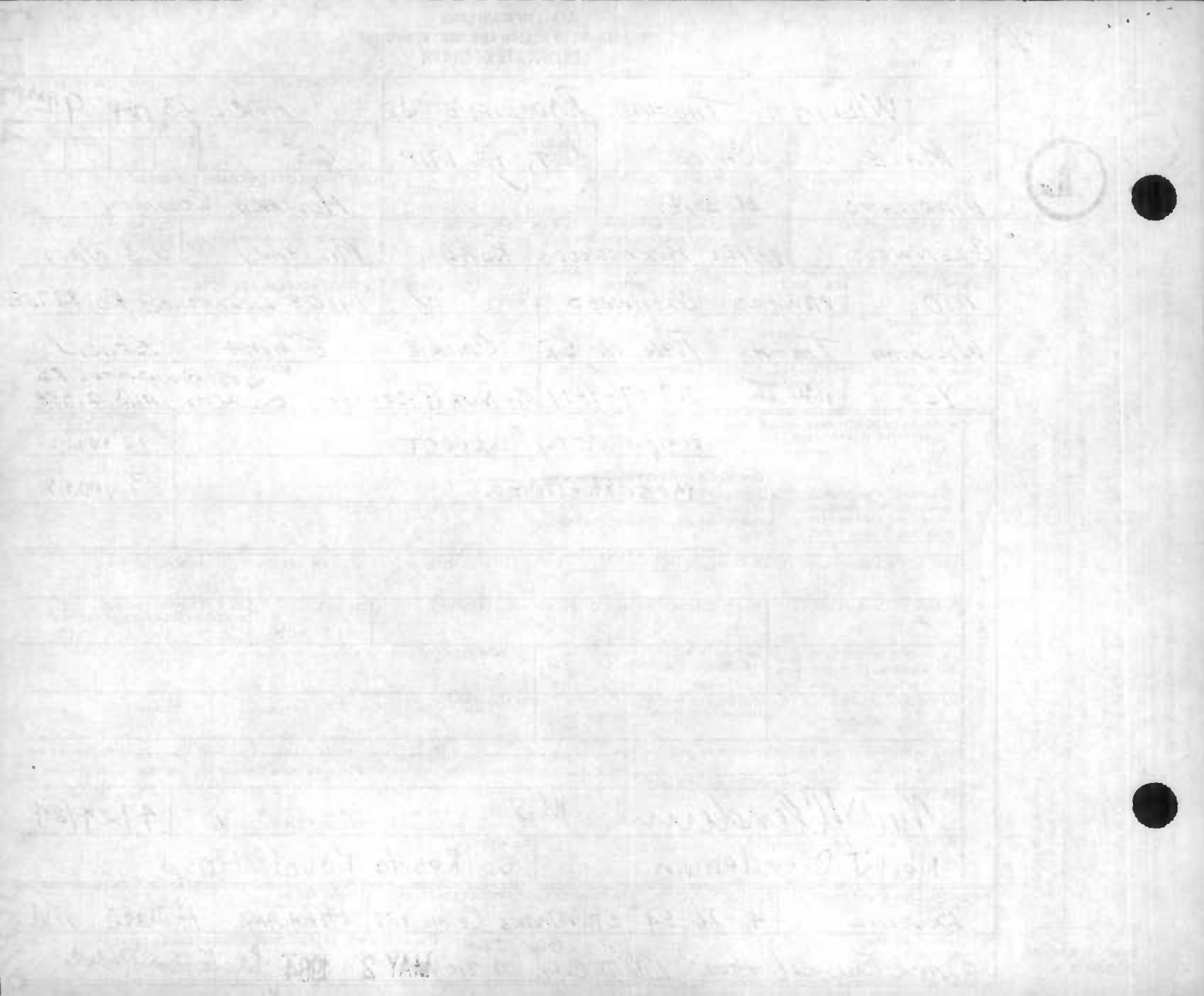
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified by the funeral director.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WILLIAM THOMAS RADCLIFFE, JR				2a. DATE OF DEATH MONTH APRIL DAY 23 YEAR 1984				2b. HOUR 9 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH SEPT. DAY 13 YEAR 1918		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.					
10. CITY OR TOWN OF DEATH GLENWOOD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14108 BURNWOODS ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MILITARY		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE MD.				13b. COUNTY HOWARD		13c. CITY OR TOWN GLENWOOD	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 14108 BURNWOODS RD 21738							
14. FATHER'S NAME FIRST WILLIAM MIDDLE THOMAS LAST RADCLIFFE SR				15. MOTHER'S MAIDEN NAME FIRST CARRIE MIDDLE EMMA LAST STERN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) UN K 217-07-9894		17. INFORMANT MS. RUTH RADCLIFFE		ADDRESS 14108 BURNWOODS RD. GLENWOOD MD 21788			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) Respiratory arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) Mesothelioma	
										(c) 3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Mary Clendenin				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil J Clendenin				22e. ADDRESS Bethesda Naval Hosp							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 4-26-84		23c. NAME OF CEMETERY OR CREMATORY ST. MARK'S CEMETERY		23d. LOCATION CITY OR TOWN HIGHLAND COUNTY HOWARD STATE MD			
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME				ADDRESS P.O. Box 268 Lillcoff City, MD 210		25a. DATE REC'D. BY REGISTRAR MAY 2 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendall			

BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles Frederick Reid, Jr			2a. DATE OF DEATH MONTH DAY YEAR April 1, 1984			2b. HOUR M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4-25-98		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Columbia, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Gen. Hosp. Howard County Emergency				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROFESSOR		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Florida		13b. CITY OR TOWN FT. Lauderdale		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4407 N.W. 49th DRIVE 33319			
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES FREDERICK REID, SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE ARNOLD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 12830384		17. INFORMANT ADDRESS 5544 HIGH TOR HILL COLUMBIA MD 21045			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardiac arrest**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **Severe interstitial lung disease** unknown

DUE TO, OR AS A CONSEQUENCE OF

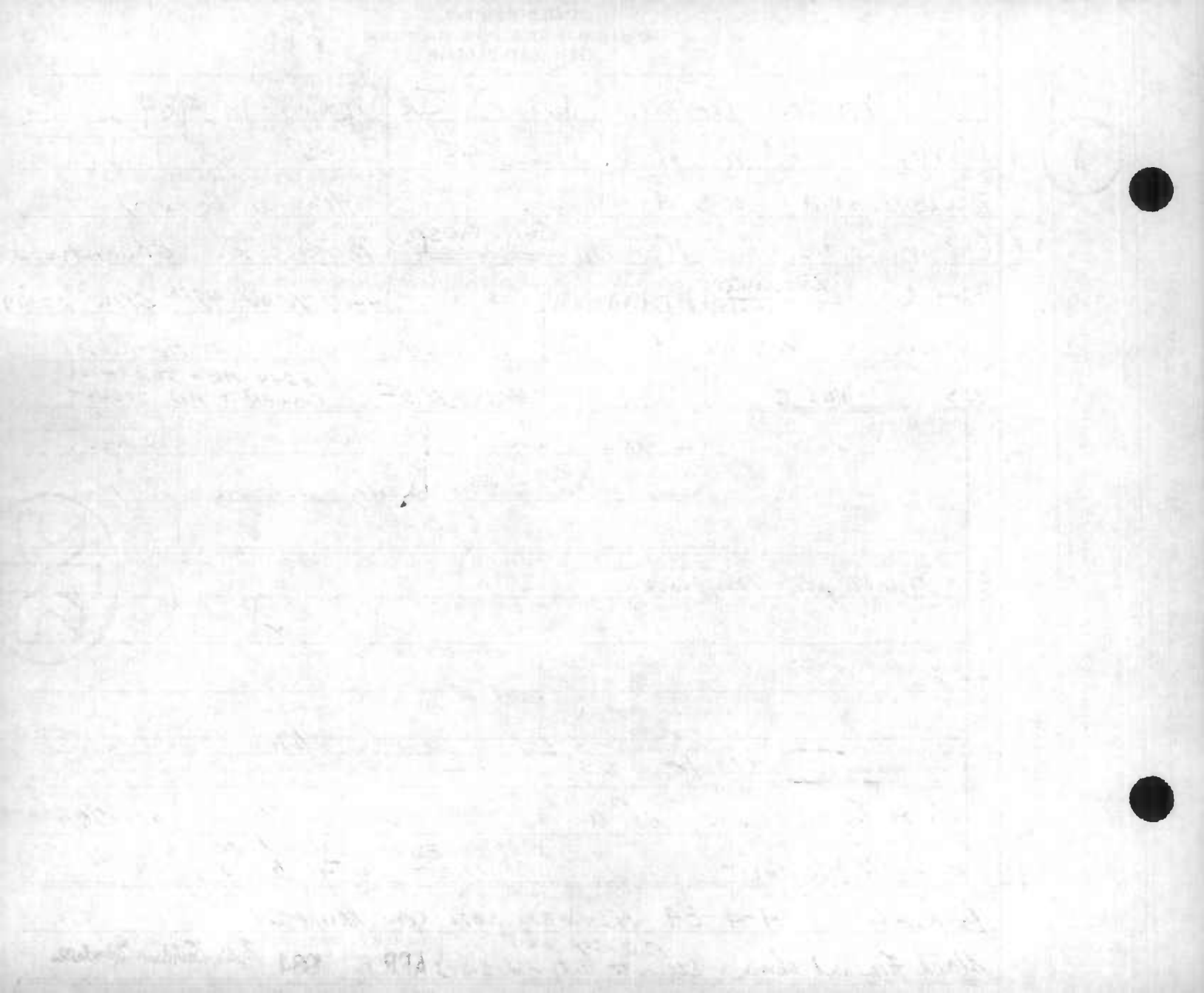
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Multiple Myeloma

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 3/26 , 19 84 , to 4/01 , 19 84 , that (I) (we) lost saw the deceased alive on 3/31/84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B.H. Minchew, M.D.				DEGREE		22c. DATE SIGNED 4/01/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.H. Minchew				22e. ADDRESS 9051 Ball, Natl. Pike Ellicott City 21043			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-4-84		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL Cem		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VA	
24. FUNERAL DIRECTOR NAME Slack Funeral Home				25a. DATE REC'D. BY REGISTRAR APR 6 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MILDRED J LAST REIS					MONTH DAY YEAR 4-9-1984					3:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Female		Black		MONTH DAY YEAR 6 19 10			73 YRS.		MONTHS DAYS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Massachusetts		U.S.A.				Howard County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Columbia		Howard County General				Housewife		Own Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS					
MASS.		Barnstable		Hyannis		233 Mitchell Way 02604					
14. FATHER'S NAME (FIRST MIDDLE LAST)			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)								
(unknown) Gomes			Mary (unknown)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
No			033-05-8754			Jeannette Coleman- Columbia, Md. 21045					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) INTRATHORACIC HEMORRHAGE											
0931											
DUE TO, OR AS A CONSEQUENCE OF (b) RUPTURE OF THORACIC AORTIC ANEURYSM											
DUE TO, OR AS A CONSEQUENCE OF (c) LUETIC ARTERIOS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from JAN 15, 19 84, to present, 19 84, that (I) (we) lost saw the deceased alive on MARCH 10, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE M. H. KELEMAN				DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/9/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M H KELEMAN				22e. ADDRESS 5999 HARBOUR FRONT COLUMBIA 21044							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			4/13/84		St. Francis Xavier			Centerville Massachusetts			
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE Funeral Home P.A. 5555 Twin Knolls Road, Columbia, Md. 21045						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 10 1984					



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 0 2 8

1 - FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) MELVIN H. RENN			2a DATE OF DEATH MONTH DAY YEAR APRIL 6, 1984			2b HOUR 1 P M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR October 5, 1901		6 AGE (IN YEARS LAST BIRTHDAY) 82		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard			
10 CITY OR TOWN OF DEATH Laurel		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9301 Scaggsville Road				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) carpenter		12b KIND OF BUSINESS OR INDUSTRY construction	
13a STATE Md		13b COUNTY Howard		13c CITY OR TOWN Laurel		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 9301 Scaggsville Rd 20707	
14 FATHER'S NAME FIRST MIDDLE LAST George W. Renn				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise E Feighenne					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b SOCIAL SECURITY NO. 218 03 4520		17 INFORMANT ADDRESS Reba Renn same as above			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4912 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Chronic bronchitis + emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>three days</u> <u>15 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diabetes.</u>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>August 9, 1983</u> to <u>April 6, 1984</u> , that (I) (we) lost saw the deceased alive on <u>April 6, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Bruce W. Gattis</u>						DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>April 7, 1984</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>BRUCE W. GATTIS</u>						22e ADDRESS <u>14333 LAUREL BOWIE RD., LAUREL, MD 20708</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE April 8, 1984		23c NAME OF CEMETERY OR CREMATORY St. Pauls Lutheran		23d LOCATION CITY OR TOWN COUNTY STATE Fulton, Maryland		
24 FUNERAL DIRECTOR NAME Donald W. on Funeral Home, Laurel, Md						25a DATE REC'D. BY REGISTRAR APR 10 1984			
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the county health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR GERTRUDE A. ROBERTSON					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) GERTRUDE A. ROBERTSON					2a. DATE OF DEATH MONTH DAY YEAR 4 24 84			2b. HOUR HOURS MIN. 5 40 P M	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 02 98		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.			
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD CTY GEN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Education		12b. KIND OF BUSINESS OR INDUSTRY School Teacher	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6602 Allview Drive 21046	
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Sherman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna June					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 384-38-9988		17. INFORMANT Gary L. Robertson Same as # 13				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4280 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) 4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Bilateral Pneumonia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4-18 , 19 84 , to 4-24 , 19 84 , that (I) (we) last saw the deceased alive on 4-24 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Krishna P. Kumar				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-25-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KRISHNA P. KUMAR				22e. ADDRESS Howard County General Hospital Columbia Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/28/84		23c. NAME OF CEMETERY OR CREMATORY Sunset Hills Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Flint Michigan			
24. FUNERAL DIRECTOR Leroy M. & Russell C. Wittke Funeral Homes						25a. DATE REC'D. BY REGISTRAR APR 27 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell	
5555 Twin Knolls Road, Columbia, Md. 21045									



NOTICE OF COLLECTION

WINDY HILL



Handwritten text at the bottom left corner, possibly a date or signature.

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1- FOR STATE REGISTRAR		MICHAEL A. SAVARESE				REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR					
MICHAEL A. SAVARESE					4-20-84		1035 ^{AM}							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR						
Male		White		March 1, 1897		87		MONTHS DAYS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		U.S.A.				Howard County MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Columbia		Lorien Nursing Home				Retired		Moulder						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS				
13b. STATE					13c. CITY OR TOWN					13d. YES <input type="checkbox"/> NO <input type="checkbox"/>				
Maryland					Howard					Columbia				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME									
MICHAEL					Savarese					Concepta Fariello				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS				
No					214-26-8384					Michael A. Savarese Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY:										Sudden				
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>														
4292 DUE TO, OR AS A CONSEQUENCE OF										Days.				
(b) <u>Acute Cerebral Vascular Accident</u>														
DUE TO, OR AS A CONSEQUENCE OF										Years				
(c) <u>Arteriosclerotic Cardiovascular Disease</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
				HOUR A.M. MONTH DAY YEAR										
				P.M. 19										
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION						
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK								CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>June 18, 1982</u> to <u>April 20, 1984</u> , that (I) (we) lost														
saw the deceased alive on <u>April 18, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE				DEGREE				22c. DATE SIGNED						
<u>Dr. J. L. E. V. N. C. D.</u>								4-20-84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS										
<u>Dr. J. L. E. V. N. C. D.</u>				<u>10802 Hickory Ridge Rd, Col, Md 21044</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE				
Burial				4/23/84		Holy Redeemer Cemetery		Baltimore		Md.				
24. FUNERAL HOME OR ADDRESS						25. DATE REC'D BY REGISTRAR								
<u>Leroy M. & Russell C. Witzke Funeral Homes P.A.</u>						<u>APR 23 1984</u>								
<u>5555 Twin Knolls Road, Columbia, Md. 21045</u>						<u>John Harrison</u>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) ERMA E. SCAGGS			2a. DATE OF DEATH MONTH DAY YEAR 4-26-84			2b. HOUR 3:30 P.M.			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 27, 1925		6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard Co., MD.			
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10700 Scaggsville Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Dept. Agr.		
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10700 Scaggsville Rd. 20707	
14. FATHER'S NAME FIRST MIDDLE LAST John M. Dasher				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian M. Moore					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.				16b. SOCIAL SECURITY NO. 217-30-4001		17. INFORMANT ADDRESS Albert H. Scaggs same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION 4140 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 4/26 19 84 , to 4/26 19 84 , that (1) we lost saw the deceased alive on 4/26 19 84 , and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above, (we) did (did not) view the body after death.									
22b. SIGNATURE John G. Lodmell MD						22c. DATE SIGNED 4/26/84		22e. ADDRESS 2901 OLNEY RD. OLNEY MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 4/28/84		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Fulton, Howard, Maryland						24. FUNERAL DIRECTOR Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. Laurel, Md. 20707			
25a. DATE REC'D. BY REGISTRAR MAY 1 - 1984						25b. REGISTRAR'S SIGNATURE John Davidson			

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NOTICE



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U.S. DEPARTMENT OF JUSTICE

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COMMUNICATIONS SECTION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR				REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
MABEL I. SHANNON								April 21, 1984				11:00 p	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR	
Female		White		Aug. 12, 1891				92 YRS.				MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
PA		USA						Howard County					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Ellicott City				943 Knoll Circle				Self-emp.				Real Estate	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS?				13d. STREET ADDRESS / ZIP CODE	
PA				Butler				YES <input type="checkbox"/> NO <input type="checkbox"/>				6611 Balto. National Pike 99916001	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				ADDRESS					
Benjamin Franklin Shannon				Amelia P. Wachsmuth									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT					
No				282 36 8937				Thompson-Miller F. H., Butler, PA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY													
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u>													
4280 DUE TO, OR AS A CONSEQUENCE OF													
(b) <u>Arrhythmia</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c) <u>congestive heart failure</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Parkinsons disease</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
				HOUR A.M. MONTH DAY YEAR									
				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>4/18/1984</u> to <u>4/13/1984</u> , that (I) (we) last saw the deceased alive on <u>4/13/1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
<u>Wendy Wosen</u>				M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				<u>4/22/84</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
<u>Wendy Wosen ABDE, MD</u>				<u>5411 Old Frodoe Rd. E</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Removal-Burial				4/25/84		North Cemetery				Butler, PA			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Henry W. Jenkins & Sons Co.				APR 24 1984				<u>Julia Davidson</u>					
NAME				ADDRESS									
4905 York Road				Balto., MD 21212									

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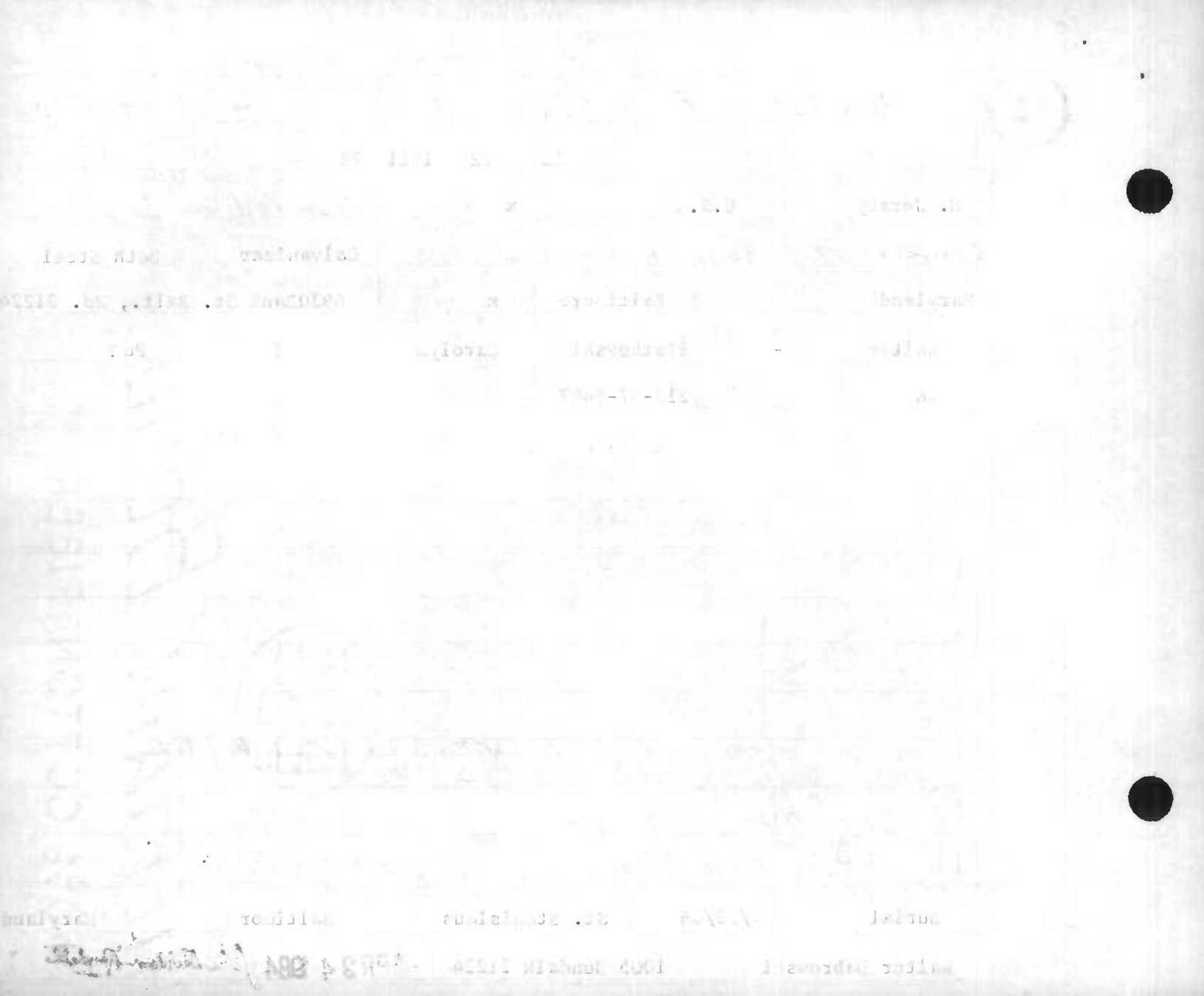
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner will be notified about it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Walter F Siatkowski					2a. DATE OF DEATH MONTH DAY YEAR 4 18 84				
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 12 22 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		2b. HOUR 8 ⁰⁰ P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Columbia, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9026 Rillon Row				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Galvanizer		12b. KIND OF BUSINESS OR INDUSTRY Beth Steel	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6930 Bank St. Balt., Md. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Walter - Siatkowski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carolyn ? Puc							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-07-8487		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) CANCER of Lung (not ill) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/18/84 to 3/18/84 , that (I) (we) lost saw the deceased alive on 3/25/84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ben Elie Fleck MD				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ben Elie Fleck MD				22e. ADDRESS 11085 Little patrick pkwy Loc. 102					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/23/84		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Walter Dabrowski				ADDRESS 1005 Dundalk 21224		25a. DATE REC'D. BY REGISTRAR APR 24 1984		25b. REGISTRAR'S SIGNATURE Davidson	

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Viola B. Simpson		2a. DATE OF DEATH MONTH DAY YEAR April 28, 1984		2b. HOUR 2:19 M
3. SEX F Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 - 01 - 09		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady	12b. KIND OF BUSINESS OR INDUSTRY Hecht Co.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland COUNTY Howard CITY OR TOWN Columbia		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13c. STREET ADDRESS 10799 Hickory Ridge Rd. 21044	
14. FATHER'S NAME FIRST MIDDLE LAST William Walters		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Known		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-16-4752	17. INFORMANT ADDRESS Columbia, Md. 21044 B. Darlene Leubecker 11110 Wood Elves Way		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4442 Vascular Collapse DUE TO, OR AS A CONSEQUENCE OF (b) Acute pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF (c) Peripheral vein thrombosis CAUSE (a) 4442 CAUSE (b) Acute pulmonary embolus CAUSE (c) Peripheral vein thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 hours approx 6 hrs days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Atherosclerotic cardiovascular disease / s/p acute myocardial infarction				
19a. DATE OF OPERATION None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from April 2, 1984 to April 28, 1984 , that (1) (we) last saw the deceased alive on April 28, 1984 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not) visit the body after death.				
22b. SIGNATURE William Parnes	DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4-28-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William PARNES		22e. ADDRESS 11085 Little Patuxent Pkwy, Columbia, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 2 1984	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Maryland		APR 30 1984		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP

11-1-1914
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Thelma Eileen Snider			2a. DATE OF DEATH MONTH DAY YEAR 4 24 84			2b. HOUR 12 10 AM M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 10 06		6. AGE (IN YEARS LAST BIRTHDAY) 77		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 77 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.			
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE MD			13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Glenn P. Snider			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie L. Neely			13e. STREET ADDRESS / ZIP CODE GARTH Apt 6150 FORELAND 41421045			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-28-8080		17. INFORMANT (son) William L. Snider		ADDRESS 12513 Galway Dr. Silver Spring, MD 20904			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Respiratory Arrest**
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) **COPD**
(c) **Alzheimers disease**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

21C**42 YRS****YRS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

C.V.A. ASCVD

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from 9/17 , 19 80 , to 4/23 , 19 84 , that (I) (we) last saw the deceased alive on 4/23 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE Melvin J. Kordon		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melvin J. Kordon		22e. ADDRESS 2000 Century Plaza Columbia MD 21045					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 25, 1984		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park, Falls Church, Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Sauers Funeral Home, Falls Church, VA				25a. DATE REC'D. BY REGISTRAR APR 27 1984			

DOWN

PIPER



APR 27 1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVAN S. SPRIGGS.				2b. HOUR 04 27 84 00 40 AM			
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 01 24 19		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD.	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Landscape	
13a. STATE Md.		13b. COUNTY Montg		13c. STREET ADDRESS 10100 New Hampshire Ave		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jerry Spriggs		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan ?		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-09-5801	
17. INFORMANT ADDRESS 15711 Radwick Ln		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CARDIAC ARRHYTHMIAS with SHOCK PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) LA. PROSPERITY ARTERIO-SCLEROTIC HEART DISEASE, URINARY TRACT INFECTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -		21f. LOCATION STREET CITY OR TOWN COUNTY STATE -		22a. I certify that (I) (this hospital) attended the deceased from 4-26-19-84 to 4-27-19-84, that (I) (we) last saw the deceased alive on 4-27-19-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE [Signature]	
22c. DATE SIGNED 4-27-84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SUDHIR D. PATEL		22e. ADDRESS HOWARD COUNTY GEN. HOSP.		22f. DATE SIGNED 4-27-84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-1-84		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring Montg Md.	
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Wash. St. Rockville, Md. 20850		25a. DATE REC'D. BY REGISTRAR MAY 02 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION



MAHARAJA KRISHNAJI
GOVIND

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 0 3 7

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Herbert CHRISTOFF TAYLOR, JR			2a. DATE OF DEATH MONTH DAY YEAR 04-13-84		2b. HOUR 640A M
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10-04-07	6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.		
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General		12a. OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY TEXTILE	
13a. STATE md			13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST HERBERT CHRISTOFF TAYLOR			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE CELESTAIL DUERINK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. - 213096069	17. INFORMANT ADDRESS Helen T. Watson 4357 College Ave. Ellicott City, Md 21043		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4860 DUE TO, OR AS A CONSEQUENCE OF (b) metabolic acidosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia 24-48 hrs. 7-10 days					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SIMULTAN.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Remote Cerebro Vascular accident.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 4/12 19 84 to 4/13 19 84, that (I) (we) lost saw the deceased alive on 4/12 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE B.H. Minchew, M.D.		DEGREE M.D.		22c. DATE SIGNED 4/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.H. Minchew, M.D.		22e. ADDRESS 9051 BALT. NATL. PIKE ELlicott City, Md. 21043			
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE 4-16-84	23c. NAME OF CEMETERY OR CREMATORY LAKE VIEW MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE SYKESVILLE BALTO MD
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS Box 268 ELlicott City MD 21043		25a. DATE REC'D. BY REGISTRAR APR 17 1984	
				25b. REGISTRAR'S SIGNATURE Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 0 3 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH B. TUPPER			2a. DATE OF DEATH MONTH DAY YEAR 4-11-84			2b. HOUR 1 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Nov 13 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.			
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Henry Betz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clura Jones			13e. STREET ADDRESS 4809 Montgomery La.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 579581036		17. INFORMANT Paul A. Tupper			ADDRESS 13009 Claxton Dr. Laurel, Md. 20708		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 2396 IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN TUMOR DUE TO, OR AS A CONSEQUENCE OF (c) ORGANIC BRAIN SYNDROME		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE I. H. Chondhry.				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/14/84		23c. NAME OF CEMETERY OR CREMATORY Balto. Wash. Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, P.G. Co. Md.	
24. FUNERAL DIRECTOR FLECK FUNERAL HOME, INC. ADDRESS 7601 Sandy Spring Rd. Laurel Md. 20707				25a. DATE REC'D. BY REGISTRAR APR 16 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 0 3 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOAN F. WEBSTER			2a. DATE OF DEATH MONTH DAY YEAR APR 12 1984			2b. HOUR 10:55 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10 6 1929		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.	
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Marriottsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert R. Tusselbaugh		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Friedemann					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-26-8356		17. INFORMANT ADDRESS Gardner V Webster, Marriottsville			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> 4/00 DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS DAYS
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

DIABETES MELLITUS

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1974</u> , 19____, to <u>4.12.84</u> , 19____, that (I) (we) last saw the deceased alive on <u>4.12.84</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. Tadisman</u>				DEGREE MD		22c. DATE SIGNED 4.13.84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TA DADISMAN JR MD				22e. ADDRESS 5999 HARPER'S FARM COLUMBIA MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4-13-84		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Harry W. Thight				ADDRESS Sykesville		25a. DATE REC'D. BY REGISTRAR APR 18 1984	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

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Handwritten notes and signatures on lined paper, including a large signature in the center.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8411040

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARGARET S. WEST			2a. DATE OF DEATH MONTH DAY YEAR 4-7-84		2b. HOUR 12¹⁰ AM
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 02 03 22		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Quincy Mass	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD.		
10. CITY OR TOWN OF DEATH COLUMBIA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD CO. GEN HOSP. COLUMBIA		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Howard Co School System		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 8905 Old Frederick Rd. 21043	
14. FATHER'S NAME FIRST MIDDLE LAST late Thomas Sandford			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Skeldon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 022 14 9189		17. INFORMANT ADDRESS William R. West 8905 Old Frederick RD 21043	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Respiratory Failure, Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Right Hemiplegia + Global Aphasia 20 Brain Metastasis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-6-84 , 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 4-6-84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Laurence Skeldon MD				22c. DATE SIGNED 4-7-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 10'84	23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans		23d. LOCATION CITY OR TOWN COUNTY STATE Garrison Forest Balto Md.
24. FUNERAL DIRECTOR NAME ADDRESS Harry H Witzke 4112 Columbia RD Ellicott City			25a. DATE REC'D. BY REGISTRAR APR 10 1984		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



White

U.S.A.

January 1944

Refined Howard Co School System.

Refined Howard

8902 Old Frederick Rd. 21043

Ellicott City

Maryland Howard

Jane Shelton

late Thomas Sandford

023 10 0189 William R. West 8902 Old Frederick Rd 21043

No



Garrison Forest Balto Md.

April 10, 1944 Maryland Veterans

Bureau

Natty H. Wicks 4111 Columbia Rd Ellicott City

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician should be notified as soon as possible.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8411041			
1. DECEASED NAME (TYPE OR PRINT) WHEELER THOMAS KIRK WHEELER				2a. DATE OF DEATH MONTH DAY YEAR 4/10/84				2b. HOUR 7 P.M.			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 08 01 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.					
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b. KIND OF BUSINESS OR INDUSTRY Auto			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md				13c. CITY OR TOWN Crown Point		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4622 Nottingham Drive 20015			
14. FATHER'S NAME FIRST MIDDLE LAST HARRY E. WHEELER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE P. UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-01-6441		17. INFORMANT ADDRESS Mr. Myles S.K. Wheeler Box 612 Pikesville, Md 21754	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA COLON</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes Mellitus.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-29</u> 19 <u>84</u> , to <u>4-10</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>4-10</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE MD. ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-11-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. HANIF MD				22e. ADDRESS 4630 Wilkens Ave Baltimore Md 21209							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4-11-84		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Carmville Balto. Md					
24. FUNERAL DIRECTOR NAME SLICK FUNERAL HOME				ADDRESS 1501 S. 24th		25a. DATE REC'D. BY REGISTRAR APR 17 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



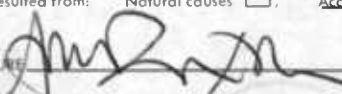
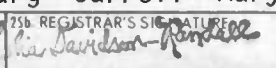
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 4 1 1 0 4 2	
1. DECEASED NAME (TYPE OR PRINT) DOUGLAS ANTHONY WILLIAMS SR.										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 4 13 1984	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 5- 24- 63		6. AGE (IN YEARS) LAST BIRTHDAY 20 YRS.	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 4 13 1984		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County		2d. HOUR 5:15 P M		
10. CITY OR TOWN OF DEATH Ellicott City			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Marriottsville Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fork Lift Operator			12b. KIND OF BUSINESS OR INDUSTRY Monroe Food		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 12374 Boncrest Drive		
14. FATHER'S NAME FIRST MIDDLE LAST David E. Williams Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daryl Jurkovich			16. SOCIAL SECURITY NO. 03-05-82/05-25-82			17. INFORMANT Mrs. Kimberly Williams		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 03-05-82/05-25-82			17. INFORMANT 12374 Boncrest Drive			17. INFORMANT Reisterstown, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR 3:10 P.M. 4-13- 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/truck collision.						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Marriottsville Rd. Howard Md.						
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					DATE SIGNED 4-14-84			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-17-84		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Eldersburg Carroll Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc 8728 Liberty Road Randallstown, Maryland 21138			25a. DATE REC'D. BY REGISTRAR APR 16 1984			25b. REGISTRAR'S SIGNATURE 					

AMERICAN BANK NOTE COMPANY
NEW YORK, N. Y.

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